PROTOCOL FOR: Craniotomy: Care of the Post-Operative Patient

DESIRED PATIENT OUTCOMES:

1. The patient will experience minimal/no complications from surgery.

2. The patient will regain optimal level of functioning, both physically and mentally.

CLINICAL ASSESSMENT/ AND CARE:

1. Neurological

   a. Assess vital signs q 4 hours x 24 hours, then q 8 hours or per LIP order.

   b. Assess level of consciousness and neuro checks q 4 hours x 24 hours, then q 8 hours or per LIP order.

   c. Check pupil size and reaction to light with VS and prn.

   d. Assess motor function with VS and prn.

   e. Assess and document spontaneous activity (i.e. verbal communication, frequent posture changes, breathing pattern, vomiting, twitches or seizures).

   f. Evaluate patient for signs and symptoms of increasing intracranial pressure. These include the following:

      1) Diminished response to stimuli

      2) Fluctuations of vital signs, increased BP, increased TCMP, decreased pulse, decreased resp.

      3) Restlessness

      4) Weakness and paralysis of extremities

      5) Increasing headache

      6) Changes in vision/pupillary changes.

   g. Monitor I&O, and keep patient slightly underhydrated (to decrease cerebral edema) per LIP order.

   h. Monitor for seizure activity and maintain safety (See Seizure Precaution Protocol).

   i. Assess safety and implement appropriate precautions (See Protocols for Soft Restraint and Fall Risk).

2. Pulmonary:

   a. Assess lung sounds q 8 hours or per LIP order.

   b. Assess patient's gag reflex, ability to cough and swallow before giving anything by mouth.

   c. If suctioning is necessary perform gentle (≤ 120 mm Hgh) suction to avoid increased intracranial pressure).

   d. Maintain patient in a lateral or semiprone position until conscious, if not contraindicated by LIP orders.

PROTOCOL FOR: Craniotomy: Care of the Post-Operative Patient

3. Thermoregulation

    a. Record temperature q 4 hours x 24 hours, then q 8 hours or per LIP order.

    b. Administer fever reducing methods as ordered: anti-pyretics, cooling blanket.

4. Pain Management

    a. Assess and document patient's report of pain: location, type, duration and severity. Use pain scale: 0-10 (0 = no pain, 10 = worst pain imaginable).

    b. Medicate as ordered, but avoid masking level of responsiveness. Document patient response to pain management regimen.

5. Mobility

    a. Assist patient to reposition frequently.

    b. Reinforce range of motion exercises.

    c. See Protocols for: Immobility and Skin Care.

6. Wound Care:

    a. Do not change dressing unless specifically ordered to do so by LIP.

    b. Assess bandage for drainage, i.e. blood, CSF.

    c. Reinforce bloodstained dressings.

REPORTABLE CONDITIONS: Notify House Officer if:

1. Vital signs are outside M.D. parameters.

2. Patient develops dyspnea.

3. HCT less than 30 or any change in HCT.

4. Dressing has increased drainage.

5. Patient has signs and symptoms of increasing intracranial pressure. Changes in neuro status.

6. Patient has changes in level of consciousness.

APPROVAL: Medical-Surgical Standards Review
Intensive Care Unit Standards Committee
Nursing Standards Committee

EFFECTIVE DATE: 11/90

REVISION DATES: 3/94, 12/97, 5/03, 9/05